YEAR 2006
OPEN ENROLLMENT BOOKLET

The Year 2006 Open Enrollment Period Runs From
October 3, 2005 THROUGH October 21, 2005

City of Milwaukee

Active Employee
Department of Employee Relations
Employee Benefits Division
City Hall, Room 706
200 East Wells Street
Milwaukee, WI 53202
(414) 286-3184

Retired Employees
Employes' Retirement System
City Hall, Room 603
200 East Wells Street
Milwaukee, WI 53202
(414) 286-3557

Active & Retired Employees
Read this Booklet
See Health & Dental Plan Choices Inside.

TABLE OF CONTENTS

Other Benefit Information enclosed in this Open Enrollment packet: <u>Active Employees</u>

- ***Benefit Information Statement***
- ***Group Life and Enhanced Group Life: (Fire & Police enrolled automatically)***
  - Supplemental Group Life Insurance Informational Brochure (3 pages).
  - 1/3 page Supplemental Group Life Insurance card application (yellow).
- ***Flexible Choices Program***
  - Two-page information; you must **enroll** or **re-enroll** during the Open Enrollment using the Telephone or Internet as described in the enclosed material. (Re-Enrollment is not automatic)
- ***Long Term Disability Program: (excludes Fire and Police)***
  - See enclosed eight-page information booklet.
- ***Deferred Compensation: see enclosed materials***

HEALTH & DENTAL OPEN ENROLLMENT

Annual Open Enrollment - October 3, 2005 through October 21, 2005

The City's Annual Open Enrollment period is upon us once again. ***Active employees,*** please see the new 2006 Employee Contributions on the first page of your Benefit Information Statement***. Retirees,*** please see your new 2006 rates on the enclosed rate chart***. The new rates may influence your health plan choice for the year 2006.***

This is your only opportunity during the year to make a change to your health or dental plan for plan year 2006**. If you are in the Basic Plan, Aurora Family Network HMO or CompcareBlue Broad Network HMO and want to stay there, you do not need to do anything.**

The Aurora Family Network HMO is a smaller HMO than the **CompcareBlue Broad Network HMO**. Be sure to check that the doctor and hospital you want are in the HMO network before you finalize your selection.

Review the information in this booklet, especially the plan comparison tables (beginning on page 10) and the enclosed Benefit Information Statement or retiree rate chart. If you want more information about a particular plan, call the health or dental plan directly and they will mail you their packet of information about provider hospitals. Their phone numbers are on page 29. You may also pick up plan information packets at the Open Enrollment Fairs as listed on page 4, or at the Employee Benefits office in City Hall Room 706, or ERS (retirees only), City Hall Room 603.

There is no "HEALTH ENROLLMENT FORM" or "DENTAL ENROLLMENT FORM" enclosed in this packet. If you are making a change and need a health or dental application, they will be available at the following locations:

- Health and Dental Carriers (see pg. 29)
- Open Enrollment Fairs (see pg. 4)
- Internet site, www.milwaukee.gov/der
- Your Departmental Payroll Personnel
- City Hall, Rom 706

YEAR 2006 HEALTH PLANS:

BASIC PLAN – The City's self-funded Indemnity Plan (administered by CompcareBlue Open Access/CMS).
Basic Plan Tier 1 and Basic Plan Tier 2 – These options are available for Active Management, HACM/RACM, WCD, MEDC, Local 494 (Electrical) and MBCTC employees only in 2006.

HMOs - The City has contracted with CompcareBlue to provide the following HMO plans:

- **CompcareBlue Aurora Family Network HMO**
- **CompcareBlue Broad Network HMO**

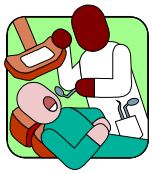
You will note from the Comparison Chart (see pg. 10) that both HMOs have the same benefit structure. We refer to this benefit structure as "UNIFORM BENEFITS." See the paragraph at the bottom of pg. 14.

The co-pay benefit level for prescription drugs is $4 for generic and $8 for brand name. Management employees enrolled in a HMO will pay a 20% co-insurance for prescription drugs with a $1000 out-of-pocket annual maximum.

YEAR 2006 DENTAL PLANS:

The City has contracted with four (4) dental plans in 2006; they are listed below:

- **WPS/Delta Dental**
- **DentalBlue**
- **Care-Plus Benefit Plans, Inc.**
- **First Commonwealth Dental/Guardian**



Something New

Basic Plan Tier 1 and Tier 2

In 2006, the City will offer a " **Basic Plan Tier 1**" and "**Basic Plan Tier 2**" plans for active Management, HACM/RACM, WCD, MEDC, Local 494 (Electrical) and MBCTC employees. The Basic Plan Tier 1 and Tier 2 are not available to other represented employees, non-management, non-represented employees and retired employees.

- Management employees who select the Tier 1 or Tier 2 plans will have the same benefits as the Basic Plan with one exception; out of network will be paid by CompcareBlue Open Access/CMS at a 70% for hospitalization and 50% for major medical.
- Employees who are eligible to select the Tier 1 or Tier 2 plans for 2006 should note that in network services will be paid the same as the Basic Plan, 100% for hospitalization and 80% for major medical.
- There will be a **$100 per person, $300 per family** deductible for the Tier 1 and Tier 2 plans the same as the Basic Plan.
- Employees who are eligible to select the Tier 1 or Tier 2 plans will pay 20% co-insurance for prescription drugs with no out of pocket maximum, the same as the Basic Plan.

The Basic Plan Tier 1 will offer the entire CompcareBlue Open Access network of providers and facilities. The Basic Plan Tier 2 will offer the entire BCBSWi PPO network of providers and facilities statewide and nationwide. Both provider directories are available on the following website www.cmsins.com and directions to navigate the website will be available at the Open Enrollment Fairs.

Healthful Links

CompcareBlue Open Access and CMS www.cmsins.com
LifestyleBlue www.bluecrosswisconsin.com
Safety & Wellness tips www.os.dhhs.gov
Smoking cessation www.covhealth.org
Wellness Walking Program www.froedtert.com
Heart Care www.columbia-stmarys.org
WI Governor's Challenge www.wisconsinchallenge.org
Physical activity to maintain good health
www.aurorahealthcare.org/services/business/getmoving/index.asp

CompcareBlue Healthy Lifestyles Program: LifestyleBlue

Your Compcare HMO coverage, through both the Aurora Family Network HMO and the CompcareBlue Broad Network HMO, offer the LifestyleBlue Healthy Lifestyles program at no cost. All of the LifestyleBlue programs with the exception of the fitness club reimbursement are available to employees and retirees in the Basic Plan, Basic Plan Tier1 and Basic Plan Tier 2. With LifestyleBlue you have access to **valuable discounts** of a variety of products and services including:

- Weight loss programs
- Smoking cessation programs
- Eye exams, eyeglasses and contact lenses
- Hearing aids and hearing exams
- Fitness club reimbursement
- And many others services

For a full list of discounts available through LifestyleBlue visit www.bluecrosswisconsin.com and click on "forms and info library," pick up a flyer at open enrollment or call a customer service representative at 1-888-239-9514. There is no additional charge to participate in this program.

CompcareBlue "Guest Membership Benefit"

For those members enrolled in the Aurora Family Network HMO or CompcareBlue Broad Network HMO, you will have access to health care benefits across the country, wherever there is a Blue Cross affiliate.

Members who are planning extended trips (greater than 90 days) or have dependents that attend college or live in **another state** are eligible for a Guest Membership. The Guest Membership will include routine services; follow up services, urgent and emergency care. This is available in the states where there is a Blue Cross and Blue Shield HMO plan. Service area requirements may apply.

For more information about the Guest Membership program, please call 1-800-331-7731.

SOMETHING TO REMEMBER

We strongly recommend that you review the benefits and cost to you of the various plans offered. Call the plans directly for more information, or attend one of the information fairs listed below.

Remember, if you do not intend to make a plan change, you do not have to do anything. This includes those members staying in the Basic Plan. The plan administrator for the Basic Plan will change from WPS to CompcareBlue Open Access/CMS in 2006. Members who are in the Basic Plan and want to continue in the Basic Plan do not have to change. Management employees who are currently enrolled in Patient Choice Tier 1 or Patient Choice Tier 2 will automatically be enrolled in the Basic Plan Tier 1 and they do not have to complete an application. It is still a good idea, to review the materials in this booklet and review the enclosed Benefit Information Statement rate chart for the cost to you of your health and/or dental plan choice for the Year 2006.

Be sure to contact your health plan or doctor's office to make sure your doctors and preferred hospital are continuing with the plan in 2006.

- All active employee enrollment forms must be in our office on or before 4:45 pm Friday, October 21, 2005.
- All retiree enrollment forms must be in the ERS office on or before 4:45 pm Friday, October 21, 2005.

No application should ever be mailed directly to the health or dental plan. See complete instructions at the back of this booklet.

OPEN ENROLLMENT INFORMATION FAIRS

The City will hold Four (4) Open Enrollment Fairs that are open to all City employees and retirees. The schedule is listed below. The Enrollment Fairs will be in the Municipal Building this year not in the City Hall Rotunda.

Thursday, October 6 - 9:00 a.m. to 2:00 p.m. ..... Frank P. Ziedler Municipal Bldg.
..... (1st Floor)
..... 841 North Broadway

Thursday, October 6 – 3:30 p.m. to 6:00 p.m. ..... Robert A Anderson Water Tower
..... 4001 South 6th Street

Thursday, October 13 - 9:00 a.m. to 2:00 p.m. ..... Frank P. Ziedler Municipal Bldg.
..... (1st Floor)
..... 841 North Broadway

Thursday, October 13 – 3:30 p.m. to 6:00 p.m. ..... Fire and Police Academy
..... 6680 North Teutonia Avenue

NOTE:
When this booklet was printed the City had not established Health/Dental terms for the year 2006 with all employee groups. As a result the employee contribution levels on your Benefit Information Statement may change.

NOTICES

➢ Notice to Employees and Retirees Regarding the Thirty-Day Rule:

Active employees and Retired employees are responsible for keeping their enrollment status current - notifying the Employee Benefits Division, Employee Retirement System or Payroll Clerk **within 30 days** of births, adoptions, marriages (including marriage to another City employee), divorces, dependents ceasing to be dependents, former dependents who become eligible dependents again, deaths and Medicare coverage. There is no penalty for a City employee or retiree who waives coverage and enrolls for coverage through a spouse or another health plan. New employees must complete health and dental applications within 30 days of their City start date and employees returning to work from layoff or any other reason must also complete health and dental applications within 30 days of their return-to-work date. (Non-compliance with this Thirty-Day Rule may expose the City and/or you to additional costs.) **There will be no exceptions to this rule.**

➢ Notice to Employees regarding the One-Family Plan Rule:

City employees who are married to each other may only carry one health plan and one dental plan between them. One spouse may carry both health and dental plans, or one spouse may carry the health plan and the other spouse may carry the dental plan. You are required to report your marriage to another city employee within 30 days of the date of your marriage. There may be financial penalties if you fail to report your marriage.

City of Milwaukee Management employees whose spouse is employed by another governmental agency may only be enrolled in a family coverage with the City of Milwaukee or with their spouse's employer, but not both.

➢ Domestic Partners

Domestic Partner medical benefits are available for some employee groups. City employees must be in a registered Domestic Partnership in order to be eligible for these benefits. There are tax implications associated with the benefits. Call Employee Benefits at 286-3184 for information.

➢ Hospital Quality

The City understands the value of hospitals providing a high quality of care. There are several measures available for review of hospital quality. All the Milwaukee area hospitals are participating in both the Leapfrog and the Wisconsin Hospital Association Checkpoint plans. For information about Leapfrog hospitals data in WI, click on http://www.leapfroggroup.org/. For information about WHA checkpoint data click on www.checkpoint.org, Reports, and then to South East Wisconsin hospitals.

DISCLAIMER:

Receiving this booklet does not necessarily imply you are eligible for City health and/or dental coverage. Only persons eligible under labor contract provisions, Common Council resolutions, or COBRA may enroll. In making these various plans available, the City of Milwaukee is not endorsing the selection of a particular plan or the level of benefits or quality of care offered by a particular plan. It is the responsibility of the employee to carefully investigate the plan and to make a decision based on this investigation. This material was prepared and sent with the cooperation of the City's health and dental plans.

BASIC HEALTH PLAN

(See the following page for information about the City of Milwaukee Basic Plan, Basic Plan Tier 1 and Basic Plan Tier 2)

The **Basic Health Plan**, administered by CompcareBlue Open Access/CMS, is designed to provide in-patient hospital benefits, medical/surgical benefits and major medical benefits. By enrolling in the Basic Health Plan you are also enrolling in the Utilization Review/Case Management (UR/CM) program (see description below). If you have questions, call CompcareBlue Open Access at 1-800-860-4885 or CMS at 1-800-472-7130.

HOSPITAL BENEFITS

Available for 365 days of inpatient care (semi-private room) for each period of disability. All medically necessary in-patient hospital services, equipment, medications and supplies are provided. In-patient care is also provided for treatment of mental health and substance abuse. Outpatient coverage is provided for first aid emergency services, medical emergencies and treatment of mental health and substance abuse.

HEALTH IMPROVEMENT PLAN (Disease Management)

The City will offer a new disease management program called the Health Improvement Plan (HIP). HIP offers an innovative, multidisciplinary approach to helping employees manage their **asthma, congestive heart failure** and **diabetes**. Program participants have experienced and increased quality of life and declined use of costly services. Through Health Coaching the goals are to **reduce patient anxieties about their condition and help them better manage their condition; identify areas of need and enhance appropriate use of the healthcare system; and reduce the need for emergency room visits and/or lengthy hospitalizations.**

Eligible participants are identified through routine reviews of submitted diagnosis and pharmacy codes in our claims system and then categorized as either high risk or low risk for one of the above three conditions. Employees or their dependents may also be referred to the program through a **hospital discharge report, a Physician or medical group referral, Case Management or by a self-referral by calling 1-866-387-8827. PARTICIPATION IS ALWAYS UP TO THE MEMBER.**

MEDICAL/SURGICAL

A variety of medical/surgical benefits are provided on a "usual and customary" basis if medically necessary, up to $10,000 per period of disability. Such professional services include surgery, in-patient medical care, maternity, anesthesia, medical consultation, oral surgery, x-ray and laboratory tests, and medical emergency care. Additional Major Medical benefits are available at 80% up to a $500,000 lifetime maximum.

MAJOR MEDICAL

Covers 80% of the cost of most routine medical expenses (if medically necessary), after the deductible have been satisfied $50.00 (retirees) per person, $150 per family maximum or $100.00 (active) per person, $300 per family maximum. Deductible will continue to accrue for three and more dependents until the third deductible has been reached. Refunds will be made for out-of-pocket expenditures above the third deductible. Coverage includes office visits and prescription drugs, as well as ambulance charges, private duty nursing, medical supplies, and a number of other items. See pg. 7 for information on the use of the City of Milwaukee Basic Health Plan Discount Drug Plan, administered by Navitus Health Solutions, LLC.

UTILIZATION REVIEW/CASE MANAGEMENT (UR/CM)

The UR/CM Program administered by CompcareBlue Open Access/CMS, is a cooperative effort by the City and its unions to improve the efficiency of health care delivery while maintaining the quality of care. This program does not shift health care costs to employees or reduce benefits. It does use medical resources in the most cost-effective manner by discouraging unnecessary hospitalizations and surgeries. Also included is a medical information service that can provide information about a wide variety of medical-related subjects. If you have questions, call CompcareBlue Open Access at 1-800-860-4885 or CMS at 1-800-472-7130.

MAJOR COMPONENTS OF THE COMPCAREBLUE OPEN ACCESS/CMS UTILIZATION REVIEW/CASE MANAGEMENT

The UR/CM program covers all City employees, Retirees, Disability Retirees, Surviving Spouses, COBRA enrollees and all dependents for which the City's Basic Plan is prime. **This program will not cover persons for whom Medicare is prime. Pre-authorization is required for all inpatient hospital admissions** (and emergency hospital admissions within 48 hours of the admission). **A PENALTY MAY BE IMPOSED IF COMPCAREBLUE OPEN ACCESS OR CMS IS NOT NOTIFIED ON A TIMELY BASIS.**

The additional UR/CM services include Continued Stay Review (monitoring of your continued treatment to assure that it is not longer than medically necessary), Second Surgical Review and Discharge Planning.

Additional information about the UR/CM program will be available at the Basic Plan (CompcareBlue Open Access/CMS) table during the Open Enrollment Fairs or by calling Employee Benefits at (414) 286-3184,CompcareBlue Open Access at 1-800-860-4885 or CMS at 1-800-472-7130.

Frequently Asked Questions (FAQ) about your City of Milwaukee Basic Plan Discount Drug Plan, Administered by Navitus Health Solutions, LLC

(Enrollees in the Basic Plan, Basic Plan Tier 1 and Basic Plan Tier 2 Only)

NOTE: Enrollees that use the Discount Drug Plan and Network Pharmacy pay only 20% in 2006.

- **Can Active and Retired City employees in the Basic Plan or the Basic Plan Tier 1 or Basic Plan Tier 2 get discounts on prescriptions?**
  Yes, employees can use their Navitus Health Solutions, LLC card to get discounts on prescriptions drugs. At Navitus Health Solutions, LLC participating pharmacies, members only pay 20% of the discounted total at the counter.

- **How does this affect my benefits under the Basic Plan, Basic Plan Tier 1 or Basic Plan Tier 2?**
  There are no changes in your benefits under the Basic Plan when you use the card.

- **Can I continue to use my pharmacy?**
  Yes. Please continue to purchase your drugs at the pharmacy of your choice. To confirm that your pharmacy is part of the Navitus Health Solutions, LLC, participating pharmacies can contact the Navitus Health Solutions, LLC member services hotline at 1-888-333-2757.

- **Will I be forced to use generic drugs with the Navitus Health Services Plan?**
  No. Your Doctor, your pharmacist, and yourself can judge which drugs are appropriate and most cost effective for you and your family. While CompcareBlue Open Access/CMS and Navitus Health Solutions, LLC services do not mandate any formulary list of drugs, Navitus Health Solutions, LLC may contact you, your doctor, and/or your pharmacist about effective drugs that are less expensive.

- **Tell me again, what are my options under the Basic Health Plan or the Basic Plan Tier I or Basic Plan Tier II?**
  One option…show your ID card with Navitus Health Solutions, LLC to the participating pharmacist and you pay 20% of the discounted price, or visit a non-participating pharmacy and pay the full retail price and complete the paperwork for reimbursement of your 80%.

WHAT IS A PRESCRIPTION DRUG FORMULARY?

The two HMO networks that have contracts with the City, Aurora Family Network HMO and CompcareBlue Broad Network HMO, have drug formularies. We have identified some frequently asked questions about drug formularies.

Q: What is a drug formulary?
A: A drug formulary is a list of drug products that can be dispensed by plan participating pharmacies.

Q: Who decides what drugs are approved for the formulary?
A: A Pharmacy and Therapeutics Committee that includes both Physicians and pharmacists establish the list. They make the determination as to which drugs are included on the formulary. The list is constantly reviewed and updated, as new drugs are available and as new generics come to market.

Q: What is the difference between a generic drug and a brand name drug in layman's terms?
A: A brand name drug is one that is still under patent by the manufacturer. Drug patents usually last about 17 years. The generic equivalent of a brand name medication has the same active ingredient as the brand name drug. Sometimes, the same company that produces the brand name drug also manufactures a generic equivalent.

Q: Who looks out for the quality of generic drugs?
A: The FDA approves generic products. These products are required to go through the same stringent testing as their brand name counterparts. If the generic product is found to be "bio-equivalent", the FDA gives it an AB rating. This means that there is no discernable difference in absorption, distribution, and elimination from the brand name product. By law in Wisconsin, only AB rated drugs may be dispensed.

Q: How do I know if a prescribed drug is on the formulary?
A: Your physician or clinic has a copy of the formulary. It is also available at the following website, www.bluecrosswisconsin.com. Ask your physician to check to make sure that your prescription is on the formulary at the time that the prescription is written.

Q: What if I forget and find out at the pharmacy that my prescription is not covered?
A: Ask the pharmacist to call your physician to see if the prescription can be changed to a drug that is on the formulary.

TIP
If you are going on vacation, try to take only the quantity of medication you will need to last for the duration of your trip. Many people lose their prescription medication while on vacation and refills due to lost, stolen or destroyed medication are not covered.

NOTE:
When you select an HMO, you must also select a Primary Care Physician (PCP) for yourself and each member of your family. If the PCP leaves the HMO plan before the end of the year, you must select a new PCP offered by that HMO plan. The City cannot guarantee that your Primary Care Physician will be with your HMO plan for the entire year.

HMO ZIP CODE LISTING FOR RETIREES

INSTRUCTIONS:

You may enroll in any HMO plan as long as your home zip code is listed below and the one letter code for the HMO you select appears after your zip code. There is no zip code requirement for enrollment in the BASIC PLAN, BASIC PLAN TIER 1 and BASIC PLAN TIER 2. *This list is for informational purposes only. It is not legally binding; it is subject to change without notice. If you have questions about a specific zip code, call the plan's Customer Service area.*

After each zip code you will find a one-letter code for each HMO plan available (**A** = Aurora Family Network, C = CompcareBlue Broad Network) you may only apply for those HMOs that serve that particular zip code. If an HMO is not listed for the zip code where you reside, you cannot enroll in that HMO.

53001	C	53075	CA	53146	CA	53212	CA	53585	C
53002	CA	53076	CA	53147	C	53213	CA	53919	C
53003	CA	53077	CA	53148	CA	53214	CA	53931	C
53004	CA	53078	A	53149	CA	53215	CA	53963	C
53005	CA	53079	C	53150	CA	53216	CA	54115	C
53007	CA	53080	CA	53151	CA	53217	CA	54126	C
53008	CA	53081	C	53152	C	53218	CA	54155	C
53010	C	53082	C	53153	CA	53219	CA	54173	C
53011	C	53083	C	53154	CA	53220	CA	54180	C
53012	CA	53085	C	53156	A	53221	CA	54203	C
53013	CA	53086	CA	53157	C	53222	CA	54206	C
53015	C	53089	CA	53158	CA	53223	CA	54207	C
53017	CA	53090	CA	53159	C	53224	CA	54208	C
53018	CA	53092	CA	53167	CA	53225	CA	54214	C
53019	C	53093	C	53168	CA	53226	CA	54215	C
53020	C	53095	CA	53170	C	53227	CA	54220	C
53021	CA	53096	CA	53171	CA	53228	CA	54221	C
53022	CA	53097	CA	53172	CA	53233	CA	54227	C
53023	C	53101	C	53176	C	53234	CA	54228	C
53024	CA	53102	C	53177	CA	53235	CA	54229	C
53026	C	53103	CA	53178	A	53237	CA	54230	C
53027	CA	53104	C	53179	C	53259	CA	54232	C
53029	CA	53105	CA	53181	C	53263	CA	54240	C
53031	C	53108	CA	53182	CA	53267	CA	54241	C
53033	CA	53109	C	53183	CA	53268	CA	54245	C
53036	A	53110	CA	53184	C	53270	CA	54247	C
53037	CA	53114	C	53185	CA	53274	CA	54300	C
53040	C	53115	C	53186	CA	53277	CA	54301	C
53042	C	53118	CA	53187	CA	53278	CA	54302	C
53044	C	53119	CA	53188	CA	53280	CA	54303	C
53045	CA	53120	CA	53189	CA	53281	CA	54304	C
53046	CA	53121	C	53190	C	53284	CA	54305	C
53049	C	53122	CA	53191	C	53285	CA	54306	C
53051	CA	53125	C	53192	C	53288	CA	54307	C
53052	CA	53126	CA	53194	C	53290	CA	54308	C
53056	CA	53127	CA	53195	C	53293	CA	54311	C
53057	C	53128	C	53200	CA	53295	CA	54313	C
53058	CA	53129	CA	53201	CA	53400	C	54324	C
53060	CA	53130	CA	53202	CA	53401	C	54344	C
53063	C	53132	CA	53203	CA	53402	C	54932	C
53064	CA	53137	A	53204	CA	53403	C	54935	C
53065	C	53138	CA	53205	CA	53404	C	54936	C
53066	CA	53139	CA	53206	CA	53405	C	54937	C
53069	CA	53140	CA	53207	CA	53406	C	54971	C
53070	C	53141	CA	53208	CA	53407	C	54974	C
53072	CA	53142	CA	53209	CA	53408	C	54979	
53073	C	53143	CA	53210	CA	53490	C		
53074	CA	53144	CA	53211	CA				

SUMMARY OF HEALTH INSURANCE BENEFITS FOR CITY OF MILWAUKEE

NOTE: These comparisons describe the benefit program in general terms. These benefits are subject to the terms and conditions of the master contracts.
The Basic Plan Benefits are subject to medical necessity.

BENEFIT	CITY OF MILWAUKEE BASIC PLAN (Administered by CompcareBlue Open Access/CMS). **Services may be subject to Utilization Review for medical necessity.**	CITY OF MILWAUKEE BASIC PLAN TIER 1 BASIC PLAN TIER 2 (Administered by CompcareBlue Open Access/CMS). **Services may be subject to Utilization Review for medical necessity.** **(For Management, HACM/RACM, WCD, MEDC, LOCAL 494 (ELECT) AND MBCTC Employees Only.)**	UNIFORM BENEFITS PLAN *Aurora Family Network HMO and CompcareBlue Broad Network HMO* ***Be sure to check with your HMO to determine if specific treatments are covered.***
1. Hospitalization **A. Number of Days**	365 days per disability under Basic benefits. Additional benefits may be available under Major Medical.	365 days per disability under Basic benefits; 100% in network, 70% out of the network. Additional benefits may be available under Major Medical.	Subject to aggregate lifetime maximum of $1,000,000 with no deductible or co-insurance.
B. Miscellaneous hospital Services	Medically necessary expenses covered (semi-private room).	Medically necessary expenses covered (semi-private room); 100% in network, 70% out of the network.	No deductible or co-insurance.
2. Surgical Medical Care	Pays usual & customary charges of physician.	Pays usual & customary charges of physician 100% in network, 70% out of the network.	No deductible or co-insurance.
3. Physician visits in Hospital	100% of usual & customary charges covered.	100% in network, 70% out of the network.	No deductible or co-insurance.
4. Maternity	Semi-private hospital room charges paid. Pays usual & customary charges of physician (dependent daughters covered).	100% in network, 70% out of the network.	No deductible or co-insurance.
5. X-Ray and Lab Tests (including Routine)	100% of usual & customary charges covered.	100% in network, 70% out of the network.	No deductible or co-insurance.
6. Radiation Therapy	100% of usual & customary charges covered.	100% in network, 70% out of the network.	No deductible or co-insurance.
7. Emergency Care **A. Accident (in or out of area)**	100% of usual & customary charges covered. No maximum.	100% of usual & customary charges covered. No maximum.	$25 Emergency Room Co-pay for accident or illness care **UNLESS** the patient is admitted to the hospital **OR** the patient's physician pre-authorizes the visit.
B. Illness (in or out of area)	If final diagnosis indicates such treatment was necessary-usual & customary charges covered.	If final diagnosis indicates such treatment was necessary-usual & customary charges covered.	
8. Major Medical Care **A. Lifetime Maximum**	Up to $500,000 in usual & customary charges.	Up to $500,000 in usual & customary charges.	Not Applicable.
B. Yearly Deductible	$50(retiree) per person - $150 family or $100(active) per person - $300 per family maximum.	$100(active) per person - $300 per family maximum.	Not Applicable.
C. Coinsurance/Co-payment	80% Covered, 20% paid by subscriber.	80% in network; 50% out of the network.	Not Applicable.
9. Physician Office Visits	Covered at 80% under major medical after deductible is satisfied.	80% in network; 50% out of the network after deductible is satisfied.	No deductible, co-pay, or co-insurance. Includes charges for routine office visits, well baby care visits, health education and counseling, hearing

BENEFIT	CITY OF MILWAUKEE BASIC PLAN (Administered by CompcareBlue Open Access/CMS). **Services may be subject to Utilization Review for medical necessity.**	CITY OF MILWAUKEE BASIC PLAN TIER 1 BASIC PLAN TIER 2 (Administered by CompcareBlue Open Access/CMS). **Services may be subject to Utilization Review for medical necessity.** **(For Management, HACM/RACM, WCD, MEDC, LOCAL 494 (ELECT) AND MBCTC Employees Only.)**	UNIFORM BENEFITS PLAN *Aurora Family Network HMO and CompcareBlue Broad Network HMO* ***Be sure to check with your HMO to determine if specific treatments are covered.***
			exams, family planning advice, and nutritional counseling from a primary care or specialty physician or members of their staff billed by the physician.
10. Chiropractor Office Visits	Covered at 80% under major medical after deductible is satisfied.	80% in network; 50% out of the network after deductible is satisfied.	No deductible, co-pay, or co-insurance.
11. Physical Therapy, Speech Therapy & Occupational Therapy	Covered at 80% under major medical after deductible is satisfied.	80% in network; 50% out of the network after deductible is satisfied.	No deductible, co-pay, or co-insurance. Benefits payable up to 50 visits per calendar year for **EACH** type of medically necessary therapy.
12. Immunizations & Injections (3)	Covered at 80% under major medical after deductible is satisfied.	80% in network; 50% out of the network after deductible is satisfied.	No deductible, co-pay, or co-insurance. Medically necessary injections or immunizations, including hormones, are not subject to deductible, co-pay, or co-insurance.
13. Durable Medical Equipment	Covered at 80% under major medical after deductible is satisfied.	80% in network; 50% out of the network after deductible is satisfied.	20% co-insurance, up to a maximum of $500 per member per calendar year for durable medical equipment, prosthetics and orthotics combined. Covered services include, but are not limited to, the initial acquisition of artificial limbs and eyes, cast, splints, trusses, crutches, orthopedic braces and appliances, ostomy supplies, compression hose for appropriate diagnoses, wheelchairs, hospital type beds, and artificial respiration equipment, therapeutic lenses, and initial cataract lenses.
14. Prescription Drugs (including oral contraceptives)	**Retail** Covered at 80% under major medical. The following three over-the-counter drugs are covered at 80%; Prilosec OTC, Claritin OTC and Alavert. Other over-the-counter drugs are not covered. **Mail Order** For additional savings, Mail Order will provide a three months (90 days) supply for a two months (60days) coinsurance on most maintenance drugs. There is no out of pocket maximum for retail or mail order prescription drugs.	**Retail** Covered at 80% under major medical. The following three over-the-counter drugs are covered at 80%; Prilosec OTC, Claritin OTC and Alavert. Other over-the-counter drugs are not covered. **Mail Order** For additional savings, Mail Order will provide a three months (90 days) supply for a two months (60 days) coinsurance on most maintenance drugs. There is no out of pocket maximum for retail or mail order prescription drugs.	Drugs and biologicals co-pay $4.00 generic and $8.00 brand for 30-day supply. Brand name co-pay applies if no generic is available. Member requested brand name drugs are subject to the brand co-pay **PLUS** the difference between the generic and the brand name drug. Over-the-counter drugs are not covered. All Management active employees have a 20% co-insurance for prescription drugs with a $1000 per person or per family out of the pocket maximum.

BENEFIT	CITY OF MILWAUKEE BASIC PLAN (Administered by CompcareBlue Open Access/CMS). **Services may be subject to Utilization Review for medical necessity.**	CITY OF MILWAUKEE BASIC PLAN TIER 1 BASIC PLAN TIER 2 (Administered by CompcareBlue Open Access/CMS). **Services may be subject to Utilization Review for medical necessity.** **(For Management, HACM/RACM, WCD, MEDC, LOCAL 494 (ELECT) AND MBCTC Employees Only.)**	UNIFORM BENEFITS PLAN ***Aurora Family Network HMO and CompcareBlue Broad Network HMO*** ***Be sure to check with your HMO to determine if specific treatments are covered.***
15. Allergy Care	Covered at 80% under major medical after deductible is satisfied.	80% in network; 50% out of the network after deductible is satisfied.	No deductible, co-pay, or co-insurance.
16. Mental Health and Substance Abuse, Drug and Alcohol Abuse **A. Outpatient Hospital, Approved Facilities, and Office Calls**	$2000 payable at 100%.	$2000 payable at 100% in network; 70% out of the network.	20 visits at 100% for Transitional Treatment; 25 visits at 100% for outpatient; Additional 27 visits at 50% for non-inpatient services.
B. Inpatient Hospital	Inpatient/Transitional: 60 days per calendar year with a renewing benefit after 120 days. This benefit does not reduce the non-Psychiatric benefits for hospitalization. Two days of transitional care is equal to 1 day of inpatient. An additional $2000 at 80% under major medical (maximum $1600).	Inpatient/Transitional: 60 days per calendar year with a renewing benefit after 120 days. This benefit does not reduce the non-Psychiatric benefits for hospitalization. Two days of transitional care is equal to 1 day of inpatient. An additional $2000 at 80% in network, 50% out of the network under major medical (maximum $1600 in network; $1000 out of the network).	20 days at 100%. This benefit is subject to the State mandate.
17. Organ Transplants	All non-experimental and non-investigational care is covered as limited by the plan. Donor Searches/Procurements- $10,000 per transplant procedure; private duty nursing $10,000 per transplant procedure; ambulance $2,000 per transplant procedure.	All non-experimental and non-investigational care is covered as limited by the plan; covered at 80% in network; 50% out of the network. Donor Searches/Procurements- $10,000 per transplant procedure; private duty nursing $10,000 per transplant procedure; ambulance $2,000 per transplant procedure.	No deductible, co-insurance, or co-pay for hospital and physician service. Drug co-pays apply for transplant related drugs. Aggregate lifetime transplant maximum is $500,000 that accrues to $1,000,000 aggregate. Covers heart, heart/lung, liver, lung, kidney, kidney/pancreas, bone marrow, parathyroid, and musculo/skeletal.
18. Ambulance	Covered at 80% under major medical after deductible is satisfied	80% in network; 50% out of the network after deductible is satisfied	Surface ambulance $300 payable in full, charges in excess of $300 payable at 80%. Air ambulance $1,000 payable in full, charges in excess of $1,000 payable 80%. ***Co-insurance is waived for approved hospital-to-hospital transfers.***
19. Private Duty Nursing	Covered at 80% under major medical after deductible is satisfied	80% in network; 50% out of the network	Home Health Care - No deductible, co-pay, or co-insurance. Limited to 50 visits per calendar year.
20. Oral Surgery	13 specific oral surgical procedures provided, including gingivectomy, alveolectomy & apicoectomy covered at 80% under major medical after deductible is satisfied	13 specific oral surgical procedures provided, including gingivectomy, alveolectomy & apicoectomy; 80% in network; 50% out of the network	No deductible, co-pay, or co-insurance. Consultation not covered unless oral surgery performed on the same day. Limited to the following procedures: - Surgical removal of bony impacted teeth - Excision of tumors, cysts of the jaws, cheeks, lips, tongue, roof of mouth when such conditions require pathological examination - Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips,

BENEFIT	CITY OF MILWAUKEE BASIC PLAN (Administered by CompcareBlue Open Access/CMS). Services may be subject to Utilization Review for medical necessity.	CITY OF MILWAUKEE BASIC PLAN TIER 1 BASIC PLAN TIER 2 (Administered by CompcareBlue Open Access/CMS). Services may be subject to Utilization Review for medical necessity. (For Management, HACM/RACM, WCD, MEDC, LOCAL 494 (ELECT) AND MBCTC Employees Only.)	UNIFORM BENEFITS PLAN *Aurora Family Network HMO and CompcareBlue Broad Network HMO* *Be sure to check with your HMO to determine if specific treatments are covered.*
			tongue, roof and floor of mouth - Apicoectomy - Excision of exostosis of jaws and hard palate - Treatment of fractures of facial bones - External incisions and drainage of cellulitis - Incision of accessory sinuses, salivary glands or ducts - Gingivectomy - Alveolectomy - Frenectomy - Removal of retained root - Gingival and Apical curettage.
21. TMJ Treatment	Benefit is limited to 80% of charges related to diagnosis and treatment of TMJ dysfunction syndrome: NON SURGICAL TREATMENT IS LIMITED TO $1250 PER YEAR for the following: - physician and specialist consultation - rehabilitative therapy services including TENS therapy - the adjustment of corrective appliance - charges for the fitting and installation of corrective splints to a maximum of $520 MAXIMUM BENEFIT PAYABLE OF $1250 PER YEAR.	Benefit is limited to 80% in network of charges related to diagnosis and treatment of TMJ dysfunction syndrome, 50% out of the network: NON SURGICAL TREATMENT IS LIMITED TO $1250 PER YEAR for the following: - physician and specialist consultation - rehabilitative therapy services including TENS therapy - the adjustment of corrective appliances - charges for the fitting and installation of corrective splints to a maximum of $520 MAXIMUM BENEFIT PAYABLE OF $1250 PER YEAR.	Benefit is limited to 80% of charges related to diagnosis and treatment of TMJ dysfunction syndrome for the following: - physician and specialist consultation - rehabilitative therapy services including TENS therapy - up to ten (10) office visits within a six month period for the adjustment of corrective appliances - charges for the fitting and installation of corrective splints to a maximum of $520.
22. Skilled Nursing Home Care (after hospitalization)	30 days per disability under basic benefits at 100%. An additional 90 days under major medical benefits at 80% after the deductible is satisfied.	30 days per disability under basic benefits covered at 100% in network, 70% out of the network. An additional 90 days under major medical benefits covered at 80% in network, 50% out of the network after the deductible is satisfied.	No deductible, co-pay, or co-insurance. Patient must be admitted within 24 hours of a covered hospital admission and care must be skilled. A maximum of 120 days per benefit period. Benefit periods must be separated by at least sixty (60) days without confinement. Benefits are payable at DHSS maximum daily rates or less if negotiated with participating providers.
23. Hospice Care	COVERED at 100%.	COVERED at 100% in network; 70% out of the network.	No deductible, co-pay, or co-insurance. Hospital or home hospice care covered, depending on the decision of the individual's primary care physician, who must certify that the participant's life expectancy is six (6) months or less. In Hospital care is limited to 30 days per calendar year.
24. Vision Care	NOT COVERED	NOT COVERED	Routine Vision Care Annual Exam including the prescription of eyewear, but no coverage for eyeglasses or contact lenses. Discounts are available under the LIFESTYLE BLUE program.
25. Physicians' Charges for Routine Physical Exams/ Well Care Services	Covered at 80% under major medical after deductible is satisfied.	80% in network; 50% out of the network after deductible is satisfied.	No deductible or co-insurance.

BENEFIT	CITY OF MILWAUKEE BASIC PLAN (Administered by CompcareBlue Open Access/CMS). Services may be subject to Utilization Review for medical necessity.	CITY OF MILWAUKEE BASIC PLAN TIER 1 BASIC PLAN TIER 2 (Administered by CompcareBlue Open Access/CMS). Services may be subject to Utilization Review for medical necessity. (For Management, HACM/RACM, WCD, MEDC, LOCAL 494 (ELECT) AND MBCTC Employees Only.)	UNIFORM BENEFITS PLAN *Aurora Family Network HMO and CompcareBlue Broad Network HMO* *Be sure to check with your HMO to determine if specific treatments are covered.*
including Well Baby Care			
26. Hearing Exams	Covered at 80% after deductible is satisfied. Under major medical when there is a medical condition (not for the purpose of prescribing hearing aids).	Covered at 80% in network; 50% out of the network. Under major medical when there is a medical condition (not for the purpose of prescribing hearing aids).	No deductible or co-insurance. Covered only if performed by primary care physician or approved specialty physician.
27. Hearing Aids	NOT COVERED	NOT COVERED	NOT COVERED (Discounts are available under the LIFESTYLE BLUE program.)
28. Health Education & Counseling	NOT COVERED	NOT COVERED	No deductible or co-insurance. Covered only if performed by primary care physician.
29. Nutritional Counseling	Nutritional counseling for the treatment of morbid obesity is covered at 80% under major medical after deductible is satisfied.	Nutritional counseling for the treatment of morbid obesity is covered at 80% under major medical after deductible is satisfied.	No deductible or co-insurance. Covered only if performed by primary care physician.
30. Infertility Services (charges for treatment after Diagnosis of Infertility)	NOT COVERED	NOT COVERED	No benefits for services primarily for the purpose of treating or reversing infertility or for artificial insemination services including donor service or other forms of fertilization including prescription drugs for infertility.
31. Physical Fitness	NOT COVERED	NOT COVERED	Discounts are available under the LIFESTYLE BLUE program.
32. Home Health Care	Up to 40 visits per year when medically necessary under basic benefits. An additional 40 days under major medical covered at 80% per calendar year after the deductible is satisfied.	Up to 40 visits per year when medically necessary under basic benefits at 100% in network; 70% out of the network. An additional 40 days under major medical at 80% in network; 50% out of the network per calendar year after the deductible is satisfied.	Home Health Care - 50 visits per year.
Dependent Coverage	Include employee's spouse; eligible dependent children, stepchildren, foster children, grandchildren (if the parent is an eligible dependent child under the age of 18), adopted children and children placed for adoption as mandated by the State or Federal government. **Coverage** for dependent children is through the end of the calendar year in which the dependent child turns 19 **OR** through the end of the calendar year the dependent child turns 25 if the dependent is a full time student or IRS dependent (You must provide more than 51% of the support and maintenance to the dependent child.). If a dependent marries or loses eligibility, coverage is through the end of the month.		
			Policy Deductible NONE Lifetime Maximum Benefit $1,000,000

"UNIFORM BENEFITS" does not mean that each HMO will treat all illnesses in the same manner. Nor does it require that each and every service be identically covered. HMOs retain the right to substitute services in such a manner as to maintain quality care of the patient. However, maximums, deductibles, co-pay amounts, or co-insurance specified in this document cannot be altered. Treatment will vary based on the needs of the patient, the physicians involved and the managed care policies and procedures of each insurance plan.

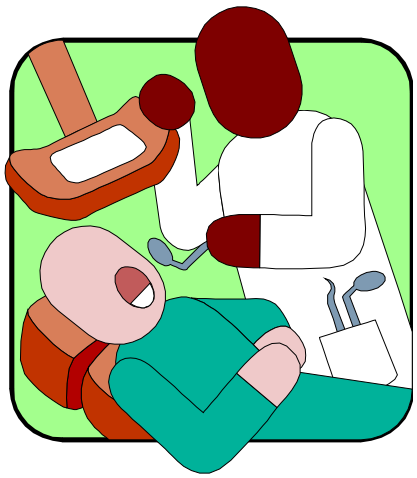
CITY OF MILWAUKEE DENTAL PLAN COMPARISON CHART
(Retirees are not eligible for Dental Coverage)

NOTE: These comparisons describe the benefit program in general terms. These benefits are subject to the terms and conditions of the master contracts.

	CARE-PLUS PREPAID PROGRAM	DENTALBLUE	FIRST COMMONWEALTH DENTAL	CITY WPS/DELTA DENTAL PLAN		
				Police	Fire	General
ANNUAL MAXIMUM	Maximum Plan Allowance	Maximum Plan Allowance	Maximum Plan Allowance	$1,000	$1,000	$1,000
DEDUCTIBLE **Single** **Family**	 None None	 None None	 None None	 $25 $75	 $25 $75	 $25 $75
BENEFITS						
DIAGNOSTIC **Oral Exam, X-Rays**	Covered	Covered	Covered	You Pay 20%	You Pay 20%	Covered[1]
PREVENTIVE **Cleaning, Fluoride, Sealants**	Covered	Covered	Covered	You Pay 20%	You Pay 20%	Covered[1]
RESTORATIVE **Fillings, Crowns**	Covered[2]	Covered[3]	Covered[3]	You Pay 20%	You Pay 20%	You Pay 20%
PROSTHODONTICS **Bridges, Dentures**	Covered[2]	Covered[3]	Covered[3]	You Pay 20%	You Pay 20%	You Pay 20%
PROSTHETICS **Denture Repairs**	Covered	Covered	Covered	You Pay 20%	You Pay 20%	You Pay 20%
ORAL SURGERY[1] **Simple Extractions**	Covered	Covered	Covered	You Pay 20%	You Pay 20%	You Pay 20%
ENDODONTICS **Root Canals**	Covered	Covered	Covered	You Pay 20%	You Pay 20%	You Pay 20%
PERIODONTICS[1] **Treatment of Gums & Tissue**	Covered	Covered	Covered	You Pay 20%	You Pay 20%	You Pay 20%
ORTHODONTICS **Maximum** **Copayment** **Deductible** **Age Limit** **Example: $3,500 Case**	 None 50% up $750 None None You Pay $750	 None 50% up to $750 None None You Pay $750	 None 50% up to $750 None None You Pay $750	 $2,000 You Pay 40% $25 Age 25 You Pay $1525	 $1,000 You Pay 40% $25 Age 19 You Pay $2525	 $1,200 You Pay 50% $25 Age 25 You Pay $2325

FOOTNOTES:

1. **Covered at 100% of usual, customary and reasonable charges.**
2. **Covered with base metal or noble metal, High Noble metal extra.**
3 **Noble and high noble metal is extra. Only Base Metal covered at 100%. Some dentists do not use Base Metal.**



Notice to Enrollees in the City of Milwaukee's Nonfederal Governmental Group Health Plan

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes certain requirements on group health plans beginning with plan year anniversary dates after June 30, 1997. Other requirements apply beginning with plan year anniversary dates occurring on or after January 1, 1998. HIPAA provides that the plan sponsor of a self-funded nonfederal governmental plan may elect to exempt the plan from any or all of the following requirements:

1. **Limitations on preexisting condition exclusion periods**.
   A preexisting condition exclusion period may not exceed 12 months, and must be reduced, under certain circumstances, by prior medical benefits coverage an individual has had.
2. **Special enrollment periods**.
   Group health plans are required to provide a 30-day special enrollment period for individuals and dependents that do not enroll in the plan at the first opportunity because they have other coverage and subsequently lose that coverage. Also, if a plan provides dependent coverage and a person becomes a dependent through marriage, birth, adoption or placement for adoption, the plan must provide a special enrollment period of not less than 30 days.
3. **Prohibitions against discriminating against individual participants and beneficiaries based on health status**. A group health plan may not establish enrollment rules (including continued eligibility) for an individual based on any of the following health status-related factors:
   - medical condition (physical and mental illnesses)
   - claims experience
   - receipt of health care
   - medical history
   - genetic information
   - evidence of insurability
   - and disability
4. **Standards relating to benefits for mothers and newborns.**
   (Effective for plan years beginning on or after January 1, 1998). Group health plans offering health coverage for hospital stays in connection with the birth of a child must provide health coverage for mother and child for a minimum period of time, generally 48 hours for a normal vaginal delivery, and 96 hours for a cesarean section.
5. **Parity in the application of certain limits to mental health benefits.**
   (Effective for plan years beginning on or after January 1, 1998). Group health plans offering mental health benefits may not set annual or lifetime limits on mental health benefits that are lower than limits for medical and surgical benefits. A plan that does not impose an annual or lifetime limit on medical and surgical benefits may not impose a limit on mental health benefits. These requirements do not apply to benefits for substance abuse or chemical dependency.

The City of Milwaukee has elected to exempt its Basic Health Plan from all of the above requirements. The City of Milwaukee's Basic Health Plan currently voluntarily provides certain benefits similar to requirements 1, 2 (with respect to dependent coverage only), 3 and 4 above.

The exception from these Federal requirements will be in effect for the plan years beginning January 1, 2006 and ending December 31, 2007.

Any questions concerning this notice may be directed to:

Employee Benefits Manager
200 E. Wells St.
City Hall, Room 706
Milwaukee, WI 53202
(414) 286-3184

This notice is provided to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Important Information About Your COBRA continuation coverage Rights

What is continuation coverage?

Federal law requires that group health plans (including the City of Milwaukee Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee covered under the group health plan, a covered employee's spouse, and dependent children of the covered employee.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who is not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan, including: open enrollment and special enrollment rights. Specific information describing continuation coverage can be obtained from the Department of Employee Relations, Employee Benefits, 200 East Wells, Milwaukee, WI 53202, 414-286-3184, attention: Crystal Owens.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage may be continued for up to 18 months. In the case of losses of coverage due to an employee's death, divorce or legal separation, the employee's enrollment in Medicare or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to 36 months.

Continuation coverage will be terminated before the end of the maximum period if any required premium is not paid on time, if a qualified beneficiary becomes covered under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary, if a covered employee enrolls in Medicare, or if the employer ceases to provide any group health plan for its employees. Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the City of Milwaukee Employee Benefits of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage, and you must notify the City of Milwaukee Employee Benefits of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the City of Milwaukee Employee Benefits of that fact within 30 days of SSA's determination.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events include the death of a covered employee, divorce or separation from the covered employee, the covered employee's enrolling in Medicare, or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. You must notify the City of Milwaukee Employee Benefits within 60 days after a second qualifying event occurs.

How can you elect continuation coverage?

Each qualified beneficiary has an independent right to elect continuation coverage. For example, both the employee and the employee's spouse may elect continuation coverage, or only one of them. Parents may elect to continue coverage on behalf of their dependent children only. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

How much does continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). The required payment for continuation coverage for the qualified beneficiaries listed on page one of this notice is described on page one.

When and how must payment for continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment for continuation coverage with the Election Form. However, you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) If you do not make your first payment for continuation coverage within those 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover this entire period. You may contact the City of Milwaukee Employee Benefits to confirm the correct amount of your first payment.

Your first payment for continuation coverage should be sent to:

City of Milwaukee Employee Benefits
200 East Wells Street, Room 706
Milwaukee, WI 53202

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of the month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without any break. The Plan will send periodic notices of payments due for these coverage periods.

Periodic payments for continuation coverage should be sent to:

City of Milwaukee Employee Benefits
200 East Wells Street, Room 706

Milwaukee, WI 53202

Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days [or enter longer period permitted by Plan] to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.
If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

Can you elect other health coverage besides continuation coverage?

Under the Plan, you have the right, when your group health coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You may exercise this right in lieu of electing continuation coverage, or you may exercise this right after you have received the maximum continuation coverage available to you. You should note that if you enroll in an individual conversion policy you lose your right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when your conversion policy coverage ends.

For more information

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plan is available from the Plan Administrator.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA web site at www.dol.gov/ebsa.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

FLEXIBLE CHOICE PROGRAM

The City of Milwaukee is pleased to offer you the Flexible Choice Program, administered by Process Works, Inc. (*formerly The Flex Company of America).* A Flexible Spending Account, or FSA, is an important part of your overall benefit package. Through the Flexible Choice Program, you can set aside a portion of your earnings with pre-tax dollars, for everyday expenses you may have with dependent day care expenses, out-of-pocket medical expenses including dental, vision, over-the counter medications, and prescription drug expenses.

The Open Enrollment period is the proper time to enroll in the Flexible Choice Program for the first time or to renew your enrollment for the new year. Remember, your Flexible Choice enrollment **does not roll over** into the new year automatically, **you must re-enroll.** This program allows you to pay for your out-of-pocket medical and dependent care expenses with pre-tax dollars by designating a pre-set amount to be deducted from your paycheck each pay period before any taxes are computed.

See the enclosed program material for additional information.

Special Notice to All City Employees, Retirees and their Families

Women's Health and Cancer Right Act Notice
Special Rights Following Mastectomy

A group health plan generally must, under federal law, make certain benefits available to participants who have undergone a mastectomy. In particular, a plan must offer mastectomy patients benefits for:

1. Reconstruction of the breast on which the mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications of mastectomy.

The City of Milwaukee health plans comply with these requirements. Of course, the extent to which any of these items is appropriate following mastectomy is a matter to be determined by consultation between the attending physician and the patient. The City of Milwaukee health plans do not impose penalties (for example, reducing or limiting reimbursements) and do not provide incentives to induce attending providers to provide care inconsistent with these requirements.

Questions, call the Employee Benefits Office at (414) 286-3184

HOW TO ENROLL

ENROLLMENT FORMS

1) There is no "HEALTH ENROLLMENT FORM" or "DENTAL ENROLLMENT FORM" enclosed with this package. If you are making a change and need a health and/or dental application, they will be available at the following locations:
   a) Health & Dental Carrier; b) Open Enrollment Fairs (see pg. 4); c) Internet – www.milwaukee.gov/der; d) Payroll Personnel; e) City Hall, Room 706
2) If you want to change to a new health plan for the year 2006, you must complete the "HEALTH ENROLLMENT FORM".
3) If you change Dental Plans for the year 2006:
   a) Complete a "DENTAL ENROLLMENT FORM".
   b) **Retirees are not eligible for dental coverage**.
4) If you add or delete a dependent(s):
   a) Complete both a Health and Dental Enrollment Form,
   b) Write the name of the dependent in SECTION B of the Health Enrollment Form, or SECTION C of the Dental Enrollment Form application.
   c) Place a check (☑) in the appropriate box in SECTION C on the Health Enrollment Form or SECTION D on the Dental Enrollment Form.
5) If you are in an HMO or Pre-paid Dental group and are only changing a Primary Care Physician (PCP), Dental Provider or IPA/CLINIC:
   a) Contact your HMO health plan or Pre-paid dental insurance plan directly and give them the information over the phone.
   b) If this is the only change, write "PCP change only" or "IPA/CLINIC change only" or combination of both in one of the margins of the health and/or dental enrollment forms.

NOTE:

*The use of an APPLICATION for a PCP or IPA/Clinic change is only applicable during the **OPEN ENROLLMENT PERIOD**. At all other times you must contact your HEALTH or DENTAL PLAN.*

6) If you do not want health or dental coverage, contact your departmental payroll personnel or the Employee Benefits office for the appropriate "WAIVER FORM". There is no penalty for an employee or retiree who waives coverage and takes coverage through a spouse or another health plan.

Active Employees Making A Health/Dental Plan Change For the Year 2006

Your completed enrollment forms must be returned to your departmental payroll personnel by **Wednesday, October 19, 2005**.

For Retirees, Disability Retirees, Surviving Spouses & COBRA Enrollees
If you are making a Health/Dental Plan Change for the Year 2006

1 . Write **"RETIREE"** in the **JOB TITLE** box of all enrollment forms.
2 . A COBRA enrollee will write "COBRA" in the JOB TITLE box.
3 . DO NOT write anything in the CITY START DATE and RETURN TO WORK DATE boxes.

If you are eligible for both parts of Medicare (Part A and Part B),

a . Please be certain to attach a photocopy of your Medicare I.D. card, and for your spouse if applicable, to your enrollment form.
b . Since coverage under Medicare usually reduces your monthly health insurance premium, it is important you make certain that we know of your Medicare coverage and that we are charging you the correct monthly health insurance premium.

All "RETIREE" applications should be returned to the office at the address below no later than 4:45 p.m. Friday, October 21, 2005:

City of Milwaukee
Employes' Retirement System
200 E. Wells St., Room 603
Milwaukee, WI 53202

TELEPHONE NUMBERS	**LOCAL**	**800#**
Employee Benefits Division	414-286-3184	ACTIVE EMPLOYEES
Employes' Retirement System	414-286-3557	1-800-815-8418
Health Plans		
BASIC PLAN (CompcareBlue Open Access Southeastern WI)	1-800-860-4885	1-800-860-4885
BASCI PLAN (CMS) (Areas other than Southeastern Wisconsin)	1-800-472-7130	1-800-472-7130
BASIC PLAN TIER 1	1-800-860-4885	1-800-860-4885
BASIC PLAN TIER II	1-800-472-7130	1-800-472-7130
AURORA FAMILY NETWORK HMO	1-888-239-9514	1-888-239-9514
COMPCAREBLUE BROAD NETWORK HMO	1-888-239-9514	1-888-239-9514
Dental Plans		
WPS/Delta Dental	414-224-8822	1-800-275-6230
CARE-PLUS DENTAL	414-771-1711	1-800-318-7007
DENTALBLUE	1-888-223-9575	1-888-223-9575
FIRST COMMONWEALTH DENTAL/GUARDIAN	1-866-494-4542	1-866-494-4542

If you have any questions regarding your benefits, or regarding unpaid bills, or problems with service, please call your health or dental plan. **DO NOT** call Employee Benefits until you have contacted your health or dental plan and are unable to arrive at a resolution. Employee Benefits will attempt to assist you to resolve your problem, but in no case will Employee Benefits attempt to change, question or provide a medical opinion. Remember to document all your conversations with dates, times and names. We will ask you for this information when you call our office.

Notes